ADVAcates for Arkansas Veterans

**Arkansas Veterans Home at Fayetteville**
1179 N. College Avenue, Fayetteville, AR 72703
Phone: (479) 444-7001 | Fax: (479) 695-0184

**Asa Hutchinson**
**Governor**

**Nathaniel (Nate) Todd**
**Director**

Dear Applicant or Family Member:

We appreciate your interest in placing yourself or loved one in the Arkansas Veterans Home at Fayetteville. Below is some general information.

**Who can apply:**

- Veteran with an Honorable or general discharge from the military
- Spouse of veteran
- Gold Star parents

**Cost of Services:**

1. If you have a Service Connected Disability rated through the VA at 60% and unemployable OR rated at 70% or higher, it is possible that the Veterans Administration will pay for your stay here. Please provide that rating letter to us when you send in the completed application packet.
2. The cost per day for a semi-private room is $130.00. A private room is $145.00 per day.
3. If you are not a service connected disabled veteran nor have the financial resources to pay, we can help you apply for long term care support under the Arkansas Medicaid Program.
4. We do accept long term care insurance policies. Please provide that with your application packet, if applicable.
5. Medicare Part A could also pay for short term rehabilitation, if you qualify.

**Medication:**

Your medication will be billed separately to you, your responsible party and/or your prescription drug insurance carrier from the pharmacy that the facility is contracted. Veterans who receive VA Aid & Attendance compensation are the only ones who can continue to obtain medication through the VA system. The Arkansas Medicaid program pays for medications for residents who have long term care Medicaid.

The use of tobacco products are not allowed inside the facility. However, we do allow smoking in designated area outside on the ground floor. Staff can assist residents at designated times, if needed. Smoking products are lighters are kept in a secure area for the safety of residents and are not permitted in residents rooms.

If you have any questions or need assistance, please call (479) 444-7001. You are welcome to come by for a tour during regular business hours, Monday – Friday, no appointment needed.

Application Instructions:

Please provide the following documents along with completed application. These are required for consideration for admission to the Veterans Home. Packet is considered incomplete if items are missing.

1. A completed, dated and signed application for admission.

2. A Government issued DD-214 or separation records showing an Honorable Discharge with entry and separation dates. If unable to locate, please contact us and we may be able to assist.

3. Social Security card, Medicare, Medicaid, Veterans Administration and any other current insurance cards (copy of the front and back of all cards)

4. Signed release of information (ROI) forms. There are two of them in the admission packet. One is the facility ROI, please sign and date it. The other is an ROI VA form. Please sign if you have medical records from the VA. If applicant is unable to sign, the Healthcare Power of Attorney must sign the form.

5. Power of attorney documents or Guardianship documents. (if applicable)

6. For spouses of veteran – please include a copy of your marriage license

7. If you have a service connected disability rated through the VA, include written verification.

# Application for Admission to the Arkansas Veterans Home at Fayetteville

Name:_____ DOB:_____ Age:_____

Address:_____ Gender: _____

City:_____ State:_____ Zip:_____ Marital Status:_____

Phone Number:_____ Place of Birth:_____

Is this address a: _____ Nursing Home _____Assisted living facility _____ Private residence

If NH or ALF, name and address of facility: _____

SSN:_____ Medicare #:_____Other insurance:_____

_____ I am a veteran ____ I am the spouse of a veteran _____ I am a Gold Star Parent of a veteran

Branch of Service:_____Dates of service:_____Do you have your DD214:_____

If you have a service connected disability, what percent?_____Do you receive Aid & Attendance?_____

Do you have a Power of Attorney? ____yes ____no Do you have a guardian? ____yes ____no

Funeral Home Choice:_____ Phone Number:_____

Address:_____
Street City State Zip

Who should we talk to about this admission (if applicant is unable)

Name:_____

Relation to the veteran:_____ Phone number:_____

Have you been admitted to the hospital in the past 6 months or currently in the hospital? ____yes ____no

Dates:_____Location:_____ Reason:_____

Have you been seen by a doctor in the last 30 days? _____ who/where?_____

Are you having difficulty/need assistance in any of the following areas: (check all that apply)

____ Dressing ____ Bathing ____Toileting ____Walking ____Communicating needs ____ Hearing

____ Vision ____uses Oxygen ____ Wounds that are not healing ____ Catheter ____Need Special diet

____ Getting in/out of bed ____Wandering ____ tracheostomy ____ Dementia diagnoses

Other information you might want to share: _____

_____

_____

## Financial information section:

_____I know that I will be private pay/VA per diem. If so, you do not need to give financial information below

Please list the gross monthly income:

| | VA Benefits | Social Security | Military Ret Pay | Civil Service | Interest | Dividends | Wages | RR Ret | Other |
|---|---|---|---|---|---|---|---|---|---|
| Veteran | | | | | | | | | |
| Spouse | | | | | | | | | |

Please list all assets (home, auto, bonds, CDs, savings/checking accounts, etc)
to determine eligibility for VA benefits and assessment of charges

1. Description of Asset:_____Location:_____

   Owner: _____Present Value:_____

2. Description of Asset:_____Location:_____

   Owner: _____Present Value:_____

3. Description of Asset:_____Location:_____

   Owner: _____Present Value:_____

4. Description of Asset:_____Location:_____

   Owner: _____Present Value:_____

Return signed application, DD214, copy of ID, Medicare and insurance cards and releases of information to:

**Arkansas Veterans Home at Fayetteville**
**1179 North College Ave**
**Fayetteville AR 72703**

Or email to: FVH@arkansas.gov

Or fax to: **479-695-0184**

**Please check one**: _____ I am ready to move now **OR** _____ I am placing my name for the future

**I certify that have read and understand the information provided on this form and that the above answer are true and correct to the best of my knowledge/belief.**

Signature:_____ Date:_____

Check one of the following: ____ I am the applicant ____ I am a representative for the applicant

# ADMISSION CRITERIA for SKILLED NURSING HOME LEVEL OF CARE

Besides being an honorably discharged veteran, spouse, or Gold Star Parent, to be eligible for admission to the Arkansas State Veterans Home at North Little Rock, you **MUST** meet the skilled care requirements of Medicaid/Medicare in **AT LEAST TWO** of the Katz Index listed below. **You must answer YES to at least TWO of the following:**

## Katz Index of Independence in Activities of Daily Living

| Activity of Daily Living | Response | Dependence<br>WITH supervision, direction, personal assistance or total care. |
|---|---|---|
| **Bathing** | ☐ Yes ☐ No | Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing. |
| **Dressing** | ☐ Yes ☐ No | Needs help with dressing self or needs to be completely dressed. |
| **Toileting** | ☐ Yes ☐ No | Needs help transferring to the toilet, cleaning self or uses bedpan or commode. |
| **Transferring** | ☐ Yes ☐ No | Needs help in moving from bed to chair or requires a complete transfer. |
| **Continence** | ☐ Yes ☐ No | Is partially or totally incontinent of bowel or bladder |
| **Feeding** | ☐ Yes ☐ No | Needs partial or total help with feeding or requires parenteral feeding. |

Services provided by our skilled nursing facility include:

- services that are needed temporarily due to an injury or illness
- post-operative wound care, dispensing and monitoring intravenous medications
- physical therapy to help correct strength and balance issues
- speech therapy to assist residents in reclaiming their ability to communicate following a stroke
- occupational therapy to help residents to become independent again, particularly when it comes to dressing, personal hygiene and eating
- pharmaceutical, laboratory and radiology services
- social and educational activities

## RELEASE OF INFORMATION FOR ARKANSAS VETERANS HOME AT FAYETTEVILLE

***This section to be completed by nursing home only*:**

**To:**_____ **Phone:** _____

**(Name of hospital, physician, facility or other)**

_____

**(Address of hospital, physician, facility, or other)**

**********

**Medical Information to be used in considering applicant for placement**

**This section to be completed by applicant/power of attorney**

**Name:**_____ **SSN:**_____-_____-_____

**DOB**_____ **Sex:** _____**M** _____**F**

**I request authorize the release of medical information to include:**

☐ **Medication and therapies**

☐ **Advance directive, durable power of attorney, DNR, Living Will**

☐ **Last hospital discharge summary (if within the last six months)**

☐ **Outpatient treatment notes**

☐ **Drug screens/substance abuse**

☐ **Alcoholism or alcohol abuse**

☐ **T.B. skin test**

☐ **Medical history and diagnosis from last six months**

☐ **Nursing assessments for last six months**

☐ **Infection with human immunodeficiency virus (HIV/AIDS)**

☐ **Current pharmacy profile**

☐ **MDS/careplans**

☐ **Other:**_____

**Send the requested information to: Arkansas Veterans Home at Fayetteville, 1179 N. College, Fayetteville AR 72703**

**Phone: 479-444-7001** **Fax: 479-695-0184**

**Authorization:** I certify that this request has been made freely, voluntarily, and without coercion. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. Disclosure of my medical record by those receiving the above authorized information may not be accomplished without my further written consent.

_____ _____

**Resident or Responsible Party** **Date**

**********

**For releasing agent use only**

**Content of material released**

**Date released:** _____ **Released by:**_____

**NOTE: This Form is only valid for a 90 day period from date of signature**

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

# REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

**Privacy Act and Paperwork Reduction Act Information:** The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

**ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.**

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Arkansas Veterans Home at Fayetteville
1179 N. College Ave. Fayetteville, AR 72703

**VETERAN'S REQUEST:** I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

**NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM**

**AUTHORIZATION:** I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

**I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.**

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

**FOR VA USE ONLY**

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

**TYPE AND EXTENT OF MATERIAL RELEASED**

DATE RELEASED

RELEASED BY